State of South Carolina Veterans Homes

APPLICATION FOR ADMISSION

SC DEPARTMENT OF VETERANS' AFFAIRS

LEAD ★ SERVE ★ REMEMBER

State of South Carolina

State Veterans Homes

Thank you for your interest in our State Veterans Homes. We look forward to providing a pleasant and safe environment at one of our five locations for you and your loved one. Our standardized admissions process provides an easy and effective method for completing and submitting this application for placement at the State Veterans Home of your choice. Please complete the enclosed application and indicate your preference by selecting one of the locations listed below. The address and telephone number for each location is provided on page two of this packet. If you do not have a preference and would like to be placed in the first available opening, please select "First Available Opening" from the list below:

- ☐ E. Roy Stone Jr. Veterans Home, Columbia SC
- ☐ Richard M. Campbell Veterans Home, Anderson, SC
- ☐ Veterans Victory House, Walterboro, SC
- ☐ Palmetto Patriots Home, Gaffney, SC
- ☐ Veteran Village, Florence, SC
- ☐ Patriots Village, Sumter, SC
- ☐ First Available Opening

**All 6 of the State Veterans Homes are Tobacco-Free Campuses.*

Our admission application consists of the following:

- **Part 1**. Personal Admission Information – For the Veteran or Resident Representative
- **Part 2.** Medical Information – For the health care providers to complete.

It is important that Parts 1 and 2 be thoroughly completed and signed.
****Please note that incomplete applications will not be processed****

In order for an application to be considered complete, the following must be also included:

- Copy of DD 214 and/or Honorable discharge paperwork
- Copies of Insurance cards
- Copies of Power of Attorney (if applicable)
- Current Photo (optional)
- Medication List from Healthcare Provider
- Physician History and Physical or Progress Notes
- Current Immunization Records

Once complete, please return Parts 1 and 2 as well as the items listed above by mail to the facility of your choice below:

E. Roy Stone Jr. Veterans Home:
Attention: Lashonda Mayfield, RN, Admissions Coordinator E.
Roy Stone Veterans Pavilion
2200 Harden Street
Columbia, SC 29203

To schedule a tour of the facility or if you would like for us to review the application with you, please call Lashonda Mayfield, Admissions Coordinator at (803) 737-5411. No appointment is necessary to drop off an application.

Richard M. Campbell Veterans Home:
Attention: Joy Hartmann, Admissions Assistant
Richard M. Campbell Veterans Home
4605 Belton Highway Anderson, SC 29621

To schedule a tour of the facility or if you would like for us to review the application with you, please call Joy Hartmann, Admissions Assistant at (864) 965-0373. No appointment is necessary to drop off an application.

Veterans Victory House:
Attention: Stephanie Ballard, Director of Admissions
Veterans Victory House
2461 Sidneys Road
Walterboro, SC 29488

To schedule a tour of the facility or if you would like for us to review the application with you, please call Stephanie Ballard, Director of Admissions at (843) 538-3000, ext. 102 or Amy Spears, RN, Admissions Coordinator at ext. 141. No appointment is necessary to drop off an application.

Palmetto Patriots Home:
Attention: Jenna Camp, RN, Director of Admissions
120 Hampshire Drive
Gaffney, SC 29341

To schedule a tour of the facility or if you would like for us to review the application with you, please call Jenna Camp, Admissions Coordinator at (864) 491-0393. No appointment is necessary to drop off an application.

Veteran Village:
Attention: August Dawkins, RN, Director of Admissions
1200 E. National Cemetery Road
Florence, SC 29506

To schedule a tour of the facility or if you would like for us to review the application with you, please call August Dawkins, Admissions Coordinator at (843) 319-8091. No appointment is necessary to drop off an application.

Patriots Village:
Attention: Danielle Gregory, Admissions Director
Patriots Village
915 North Wise Drive
Sumter, SC 29153

To schedule a tour of the facility or if you would like for us to review the application with you, please call Danielle Gregory, Admissions Director at (839) 900-1230.
No appointment is necessary to drop off an application.

Admission Requirements:

- Veteran served active duty who was discharged under other than dishonorable conditions.
- Veteran is a citizen of South Carolina.
- Veteran meets Veterans Administration criteria for long term nursing care.

Process for Admission:

- Once a complete packet has been received it will be reviewed by the facility. The Admissions Coordinator will then schedule an appointment for a home visit. Please allow 3-4 weeks after the application has been submitted.
- Once the veteran is assessed and is accepted, he or she will be placed on a waiting list for an available bed.
  - Please begin preparation for admission at this time as we will not be able to give you an exact date for admission.
- Applications are kept on file for 12 months. Please be sure to keep a copy of your application.

Cost and Payment Information:

- The VA covers the majority of the total cost to include room and board, nursing, food, laundry services, haircuts, cable and basic personal items such as briefs and toiletries.
- The Veteran is responsible for the daily copay.
- The exception for this daily copay is a Veteran who has a 70% to 100% service-connected disability, for whom the VA pays the full cost.
- On-site pharmacy services provide medications for all Veterans. Medications (that are on the VA formulary) are ONLY provided by VA at no cost to the veteran for residents who have Aid and Attendance or those who are greater than 50% service connected.
- The Veteran is responsible for ancillary charges such as, but not limited to, the physician copay, therapy, labs and medications. These charges are billed to the Veteran's insurance such as Medicare, Medicaid, Tricare, Medicare Part D or any other supplemental insurance coverage.
- Please see the Reimbursement Frequently Asked Questions booklet for additional information.

SOUTH CAROLINA STATE VETERANS HOMES

1800 Saint Julian Place
Suite 305
Columbia, SC 29204
Reimbursement: (803) 898-8405

IMPORTANT NOTICE

Representative Payee:

- The South Carolina Department of Veterans Affairs (SCDVA) will submit an application to become representative payee of Social Security, Veterans Administration, and other established benefit source(s) only if the resident or representative, for any reason, is unable to act as his or her own payee and accounts become or risk becoming delinquent.
- An application for representative payee will also be submitted for any resident or responsible party if any billed balances are determined to be delinquent for 30 days or longer.

Setoff Debt:

- Any delinquent balances due on resident's account to SCDVA may be subject to collection under the Setoff Debt Collection Act, which is administered by the South Carolina Department of Revenue as authorized by statue.

Bed Hold:

- Per Facility bed hold policy, it will reserve the resident's bed at this published daily resident copayment rate, which applies if the resident has either a single medical leave occurrence from the facility of up to ten (10) consecutive days, or up to the first 12 days used per calendar year of all combined nonmedical leave occurrences from the facility.
- To continue to reserve the bed at the facility past the daily medical leave (10 days) or non-medical leave occurrences (12 days per year) limitations listed above, the resident or his/her resident representative will be charged for the reserved bed at the full published daily rate.

If there are any questions, please contact Reimbursement Office at 803-898-8405 or at our main line at 803-898-0084.

(Notice Revised August 01, 2024)

PART 1
PERSONAL INFORMATION

SOUTH CAROLINA STATE VETERANS HOME ADMISSION CHECKLIST

This checklist must be returned with your application packet.

Veteran's Name: _____
Physical Location of Veteran: _____
Street: _____
City: _____ State: _____ Zip Code: _____
Veteran Representative's Name: _____
Phone Number: _____ Email Address: _____

Admission Checklist

_____Personal Admission Information (2 pages)
_____State Citizenship (2nd page of Personal Admission Information Form)
_____Authorization for Release of Protected Health Information (SCDVA Form - 1 page)
_____10-5345 Request for & Authorization to Release Medical Records of Health Information (Department of Veterans Affairs form - 2 pages)
_____Application for Admission to a State Veterans Home (SCDVA Form - Page 1)
_____Advance Directives Information (SCDVA Form Page 2)
_____Authorization to Release Information, Request For Payment and Assignment of Benefits (2 pages)
_____SCDVA Benefits Demographic Form (2 pages)
_____Enrollment Application for Health Benefits - VA Form 10-10EZ (6 pages)
_____Tobacco-Free Campus Policy (2 pages)
_____List of Current Physicians (1 page)
_____Proof of Honorable Discharge (DD214)
_____Insurance Cards
_____Power of Attorney, Living Will

SECTION 2

The following forms MUST be obtained from and/or completed by the Veteran's Physician:

_____Health Care Decision Form
_____SLUMS Examination (1 page) - VAMC Form - Nursing staff may complete and sign
_____PASARR - (2 pages) - Nursing staff may complete and sign
_____2-Step Tuberculin Skin Test (TST) or single BAMT within 1 month prior to admission unless negative TST or negative BAMT test within the previous 12 months

_____Single TST or single BAMT within 1 month prior to admission (ONLY if 2-step TST or single BAMT within previous 12 months)
_____If positive TST - must include Interpretable Chest X-Ray within the previous 3 months of admission date
_____History and Physical from Primary Care Physician/Nursing Home Physician
_____Current list of medications from Primary Care Physician/MAR
_____Doctor's notes from the past 2-3 office visits
_____Immunization record to include FLU, Pneumonia Vaccines, and COVID-19 Vaccination

Admission from Nursing Home: (If applicable)

_____Information as listed above
_____Most recent full MDS assessment, Care Plan, CAAS

SOUTH CAROLINA STATE VETERANS HOME

PERSONAL INFORMATION

1. VETERAN'S NAME:_____
   NICKNAMES OR ALIAS:_____

2. HOME ADDRESS:
   a. Street:_____
   b. City:_____State:_____Zip Code:_____
   c. Phone Number:_____
   LEGAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS)
   d. Street:_____
   e. City:_____State:_____Zip Code:_____
   f. Phone Number:_____

3. LOCATION OF VETERAN: HOME:____ HOSPITAL:_____ NURSING HOME:_____
   IF OTHER THAN HOME, PROVIDE NAME, ADDRESS AND PHONE NUMBER OF THE FACILITY:
   a. Facility:_____
   b. Street:_____
   c. City:_____State:_____Zip Code:_____
   d. Phone Number:_____

4. VA CLAIM NUMBER:_____ Soc Sec NUMBER:_____

5. NAMES OF PERSONS DEPENDENT UPON (RELATIONSHIP / AGES)
   a. _____
   b. _____
   c. _____
   d. _____

6. NAME OF VETERAN REPRESENTATIVE:_____
   ADDRESS:_____
   HOME PHONE:_____ WORK PHONE:_____

7. PERSONAL PHYSICIAN:_____
   ADDRESS:_____
   PHONE:_____

8. HIGHEST LEVEL OF EDUCATION ACHIEVED:_____

9. USUAL OCCUPATION:_____
   DATE EMPLOYMENT ENDED:_____

10. COUNTRY OF BIRTH:_____STATE:_____

11. DATE OF BIRTH:_____CURRENT AGE:_____

12. VETERAN SERVICE OFFICER (VSO):_____
    COUNTRY:_____
    VSO PHONE:_____VETERAN IS IN RECEIPT OF NCS:_____
    PENSION AMOUNT:_____COMPENSATION AMOUNT:_____

VETERAN OR RESIDENT REPRESENTATIVE:

_____ _____
(Print Name: First, Middle, Last) (Date of Signature)

_____ _____
(Signature of Veteran or Resident Representative) (Relationship to Veteran)

INFORMATION ON STATE CITIZENSHIP

A citizen of South Carolina is a person who intends to maintain South Carolina as their permanent home, who has their primary family and social connections centered in the state, and who does not have a permanent residence outside of South Carolina.

Provide any one of the following to prove South Carolina citizenship:

- ☐ Drivers license, passport, Veteran ID Card, or other government-issued ID with SC address
- ☐ Statement showing South Carolina taxes withheld from pension or annuity payments
- ☐ South Carolina voter registration card
- ☐ Receipt or filed return for payment of South Carolina property or income taxes
- ☐ Verification in the United States Department of Veterans' Affairs data system

Under penalty of Law, the undersigned swears or affirms that all answers to questions in this application are correct to the best of his/her knowledge, that all questions are fully understood, and that questions and answers have been read by the Veteran or read and explained to him/her and that the Veteran understands and accepts the terms and conditions required in Part II.

VETERAN OR RESIDENT REPRESENTATIVE:

_____ _____
(Print Name: First, Middle, Last) (Date of Signature)

_____ _____
(Signature of Veteran or Resident Representative) (Relationship to Veteran)

SOUTH CAROLINA STATE VETERANS HOMES

Authorization for Release of Protected Health Information

I, _____ hereby authorize _____
(Veteran/Veteran's Representative) (Name of Facility)
to release the entire record or portions thereof, on _____
(Veteran's Name)
to the Admissions Coordinator of:

- ☐ E. Roy Stone Veteran's Pavilion - 2200 Harden Street, Columbia, SC 29203
- ☐ Richard M. Campbell Veterans Home - 4605 Belton Highway, Anderson, SC 29621
- ☐ Veterans Victory House Nursing Home - 2461 Sidneys Road, Walterboro, SC 29488
- ☐ Palmetto Patriots Home - 120 Hampshire Drive, Gaffney, SC 29342
- ☐ Veteran Village - 1200 E. National Cemetery Road, Florence, SC 29506
- ☐ Patriots Village – 915 North Wise Drive, Sumter, SC 29153

in order to assist us in evaluating this individual for potential admission to the facility.

Veteran's Name _____

Veteran's Date of Birth _____ Veteran's Social Security Number_____

The Authorization is valid for one year from the date of signing unless and earlier date, condition or event is specified here: _____

I understand that the information may include alcohol/drug abuse and/ or HIV/ARC and other infectious disease information. I do not want the following information disclosed:

_____

I understand that information disclosed may be subject to re-disclosure by the above named facility. I may cancel this authorization at any time by writing the local Privacy Officer where I received or am receiving treatment. I understand that if I cancel this Authorization it will not apply to information that has already been used or released to this authorization. I also understand that applicable law may permit or require the use, disclosure or re-disclosure of information about me without my authorization.

VETERAN OR VETERAN REPRESENTATIVE:

_____ _____
(Print Name: First, Middle, Last) (Date of Signature)

_____ _____
(Signature of Veteran/Veteran Representative) (Relationship to Veteran)

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT STATEMENT:

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Location of the VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ EMPLOYMENT ☐ OTHER *(Please specify below):*

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ PATIENT MEDICAL RECORDS *(Dates)*: _____

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS: _____

☐ VACCINATION *(Dose, Lot Number, Date & Location)*: _____

☐ ADMINISTRATIVE RECORDS: _____

☐ OTHER *(Describe)*: _____

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE OTHER THAN TREATMENT.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ SICKLE CELL ANEMIA

☐ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked unless I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

APPLICATION FOR ADMISSION TO A STATE VETERANS HOME

Veteran's Name: _____

Medical Record Number:_____

The undersigned hereby makes application for admission of the above-named individual to a South Carolina State Veteran's Home, to receive nursing care.

- ☐ E. Roy Stone Veterans Pavilion - 2200 Harden Street, Columbia, SC 29203
- ☐ Richard M. Campbell Veterans Home - 4605 Belton Highway, Anderson, SC 29621
- ☐ Veterans Victory House Nursing Home - 2461 Sidneys Road, Walterboro, SC 29488
- ☐ Palmetto Patriots Home - 120 Hampshire Drive, Gaffney, SC 29342
- ☐ Veteran Village - 1200 E. National Cemetery Road, Florence, SC 29506
- ☐ Patriots Village – 915 North Wise Drive, Sumter, SC 29153

It is understood and agreed that if admitted, the above-named individual and the person, if any, who makes this application on each individual's behalf, will obey and be bound by all rules and regulations governing the facility and its residents.

By making this application, the above-named individual and the person, if any, who makes this application on such individual's behalf give consent to said facility to administer such standard medical, surgical, dental, or other treatment as the attending physician recommends.

Consent is also given for the facility to disclose medical record information and/or release medical record documents to any outpatient provider and/or acute care hospital as needed to facilitate the provider in treating the above-named individual as referred by his attending physician, himself or his substitute decision maker.

Veteran:

_____ _____

(Print Name: First, Middle, Last) (Date of Signature)

_____

(Signature of Veteran)

Substitute Decision Maker:

_____ _____

(Print Name: First, Middle, Last) (Date of Signature)

_____

(Signature of Veteran)

ADVANCE DIRECTIVE INFORMATION

1. Does the Veteran have an Advance Directive such as Health Care Power of Attorney and/or Living Will?

   Yes:_____ No:_____

2. If yes, please attach a copy and complete the following:

   Designated Decision Maker:

   Name:_____ Relationship:_____

   Address:_____ Home Phone:_____

   _____ Business Phone:_____

3. Designee to receive personal property in the event of discharge/death?

   Name:_____ Relationship:_____

   Address:_____ Home Phone:_____

   _____ Business Phone:_____

4. Funeral Home:_____

   Address:_____ Phone:_____

5. Has the Veteran completed an agreement consenting to provide a Body Donation?

   Yes:_____ No:_____

   If yes, please attach a copy.

AUTHORIZATION TO RELEASE INFORMATION, REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

Applicant's Name: _____ Medical Record No:_____

Applicant's Address: _____ S.S. NO:_____

_____

Applicant's Date of Birth:_____

Admission Beginning:_____

The purpose of the release is to recover insurance benefits, obtain precertification and to accomplish other insurance related objections.

You may withdraw this consent at any time by written notification to the South Carolina Department of Veterans Affairs, provided action has not been taken upon authorization. Without written notice to withdraw consent, it expires at the earlier of (a) completion of the started purpose or (b) two years from date if signature.

NOTE: The execution of thus form does not authorize the release of information other than as noted. The information requested on this form is protected by State of Federal laws. All items must be completed. If information is not complete, we may not be able to comply with your request.

** I AM AWARE THAT WHEN MY MEDICAL RECORDS REFLECT INFORMATION CONCERNING PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENTS, DRUG ABUSEE, AND/OR ALCOHOLISM, AND/OR INFORMATION REGARDING HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND OTHER INFECTIOUS DISEASES, THAT THIS INFORMATION WILL BE RELEASED AS PART OF MY MEDICAL RECORDS.

INSURANCE COMPANY

I hereby request payment of an assign my insurance or medical payment benefits for medical care and maintenance to the South Carolina Department of Veterans' Affairs or its contract provider under the terms outlined by the Health Insurance Claims Policy and Produce and I hereby authorize the South Carolina Department of Veterans' Affairs to release any information from the medical records of the above- name which is necessary to fulfill the purpose of this release contract providers and:

Insurance Company:_____
(Or its Agents)

Insurance Company's Address:_____

_____

Telephone No.:_____

Policy No.:_____

Group No.:_____

Policy Holder:_____

Employer:_____

TYPE OF INSURANCE:

☐ Hospitalization

☐ Sickness & Accident

☐ Life Insurance

☐ Medicare Supplement

☐ Other_____

_____
Date

_____ _____
Witness Applicant's / Authorized Person's Signature-Relationship

MEDICAID

I request payment of authorized Medicaid benefits to be made on my behalf for any services furnished to me by or in the South Carolina Department of Veterans Affairs and its providers, including physician services. I authorize the South Carolina Department of Veterans Affairs to release any information from my medical records necessary to fulfill the purpose of this release to its contract information needed to determine these benefits or benefits for related services.

Date	Medicaid Number
Witness	Patient's/Authorized Person's Signature- Relationship

MEDICARE

I request payment of authorized Medicare benefits to be made on my behalf for any services furnished to me by or in the South Carolina Department of Veterans Affairs and its contract providers, including physician services. I authorize the South Carolina Department of Veterans Affairs to release any information from my medical records necessary to fulfill the purpose of this release to its contract providers and I authorize any holder of medical and other information about me to release to (a) Medicare and its agents and (b) the Social Security Administration or its intermediaries any information needed to determine these benefits or benefits for related services. I certify that the information given by me in applying for payment under title XVIII of Social Security Act is correct.

Date	Medicare Number
Witness	Patient's/Authorized Person's Signature- Relationship

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

I request payment Medicaid Benefits be made on my behalf for any services furnished to me by or in the South Carolina Department of Veterans' Affairs and its providers, including physician services, I authorize the South Carolina Department of Veterans' Affairs to release any information from my medical records necessary to fulfill the purpose of this releases to its contract information needed to determine these benefits or benefits for related services.

Date	Champus Number
Witness	Patient's/Authorized Person's Signature- Relationship

SC DEPARTMENT OF VETERANS' AFFAIRS
LEAD ★ SERVE ★ REMEMBER

1800 Saint Julian Place Suite 305
Columbia, SC 29204

Re: **Admission Date:**

Please complete the following information concerning the patient named above. This information will be used to qualify the patient for any possible benefits such as Social Security, Veteran benefits, Medicaid, Medicare, etc... We will use this information provided to determine sources of payment, if any, toward the charges incurred for this patient's hospitalization.
Please complete this form to the best of your ability.

Patient's Home Address		
Date of Birth	Social Security Number	Place of Birth
Name of Spouse: (wife/husband) ☐ Living ☐ Deceased ☐ Disabled	If divorced, how many years married? Spouse's Social Security Number	
Father's Name: ☐ Living ☐ Deceased ☐ Disabled ☐ Divorced	Mother's Maiden Name: ☐ Living ☐ Deceased ☐ Disabled ☐ Divorced	
Name, Address and Relationship of Contact Person:		
Does the patient have a legally appointed conservator/trustee? ☐ Yes ☐ No If yes, please provide: Name/Address: Telephone: Date Appointed: County/State:		
Does the patient have a financial Power of Attorney? ☐ Yes ☐ No If yes, please provide: Name/Address: Telephone: Date Appointed: County/State:		
Does the patient own property? ☐ Home ☐ Land ☐ Rental Property-Income Amount: Approximate Value of Property: Address of Property: In which County is Property Located:		
Does the patient's spouse own property? ☐ Yes ☐ No Approximate Value of Property: Address of Property: In which County is Property Located:		
Does the patient have any of the following? If so, indicate approximate value and location of each: ☐ Bank Account Checking: ☐ 401K, IRA, Mutual Funds, etc.: ☐ Savings Account:		
Do the patient's parents own property? ☐ Yes ☐ No Approximate Value of Property: Address of Property: In which County is Property Located:		

Patient's Income from:	**Amount:**	**Claim Number:**
Social Security		
SSI (Supplemental Security Income)		
Veterans Administration		
Civil Services		
Railroad Retirement		
S. C. State Retirement		
Other (pension, alimony, child support, etc.)		

Is patient a Veteran? ☐ Yes ☐ No	If patient is a Veteran please answer the following:	
Serial/Claim Number:	Branch of Service:	Date of Service:
Is patient's spouse a Veteran? ☐ Yes ☐ No	If yes, provide Veteran's full name:	

If the patient is a minor or a disabled adult, is the patient's parent a Veteran? ☐Yes ☐No If yes, provide Veteran's full name:		
Place and date of last employment:		
Total number of years employed:		
Previous employment / Total number of years employed by each:		
Is the patient covered by hospital insurance? ☐Yes ☐No	Name of Company:	
Policy Number: *Please attach a copy of the front and back of insurance card.*	Address: Telephone Number:	
Is the patient covered by Medicare? ☐Yes ☐No Name:	If yes, please copy the following information as it appears on the Medicare Card:	
Part A Claim Number:	Effective Date:	
Part B Claim Number: *Please attach a copy of the front and back of insurance card.*	Effective Date:	
Is the patient eligible for Medicaid? ☐Yes ☐No	Medicaid Number:	
List the name and address of the person to be billed:		
Please provide any information you feel assist us in establishing benefits or obtaining payment towards the bill:		
Name of person providing information:	Relationship to patient:	
Name of person completing this form:	Relationship to patient:	Date Completed:

This completed form should be forwarded to the Reimbursement Office, P.O. Box 485, Columbia, S.C. 29202

Note: *The attached or enclosed information is being disclosed to you from records whose privacy is protected from disclosure by federal and state law including as applicable. 45 CFR Part 160 (HIPAA); 42 CFR Part 2. (alcohol and drug treatment), and Section 44-22-100 Code of Laws of South Carolina. The applicable law or laws may prohibit you from making any further disclosure without the specific written authorization by the individual to whom it pertains or their authorized representative, or as otherwise permitted or required by law. A general authorization for release of information is not sufficient for this purpose unless it conforms to the specific requirements of the applicable law or laws. Further disclosure not in accordance with the applicable federal and state law may result in civil and / or criminal penalties.*

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING ENROLLMENT APPLICATION FOR HEALTH BENEFITS

Please Read Before You Start . . . What is VA Form 10-10EZ used for?

For Veterans to apply for enrollment in the VA health care system. The information provided on this form will be used by VA to determine your eligibility for medical benefits and on average will take 30 minutes to complete. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Where can I get help filling out the form and if I have questions?

You may use ANY of the following to request assistance:

- Ask VA to help you fill out the form by calling us at 1-877-222-VETS (8387).
- Go to www.va.gov/health-care for information about VA health benefits.
- Contact the Enrollment Coordinator at your local VA health care facility.
- Contact a National or State Veterans Service Organization.

Definitions of terms used on this form:

- SERVICE-CONNECTED (SC): A VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A VA determination that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A VA determination that a service-connected disability is not severe enough to warrant monetary compensation.
- TOXIC EXPOSURE RISK ACTIVITY (TERA): Veterans who were exposed to one or more of the following hazards or conditions during active duty, active duty for training, or inactive duty training (this is not an all-inclusive list): air pollutants, chemicals, occupational hazards, radiation, and warfare agents. For more information visit https://www.publichealth.va.gov/exposures/.
- NONSERVICE-CONNECTED (NSC): A Veteran who does not have a VA determined service-related condition.
- REPORTABLE INCOME: The minimum amount of gross income required to file a Federal income tax return according to the Internal Revenue Code of 1954 Section 6012(a).

Getting Started: **ALL VETERANS MUST COMPLETE SECTIONS I - III.**

Directions for Sections I - III:

Section I - General Information: Answer all questions.

Type of Benefit Applying For:

- **Enrollment -** Veterans applying for enrollment for the Full Medical Benefits Package provide in 38 C.F.R. 17.38 must meet the eligibility requirements of 38 C.F.R. 17.36.
- **Registration** - For Registrations, only complete Sections I, II, and III. Enrollment not required - Veterans requesting an eligibility assessment, clinical evaluation, care or treatment pursuant to a special treatment authority provided in 38 C.F.R. 17.37:
  - Care for a Veteran with a VA service connected disability rating of 50% or greater
  - Care for a VA rated service connected disability
  - Care for psychosis or other mental illness
  - Care for Military Sexual Trauma treatment (MST)
  - Catastrophically Disabled Examination
  - A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty can receive VA care for the 12-month period following discharge or release
  - Care for a Veteran participating in VA's vocational rehabilitation program under 38 U.S.C. 31

Section II - Military Service Information: If you are not currently receiving benefits from VA, you may attach a copy of your discharge or separation papers from the military (such as DD-214 or, for WWII Veterans, a "WD" Form), with your signed application to expedite processing of your application. If claiming a Military Exposure, you may provide us a written statement, or statements from people who witnessed your claimed exposure(s). If you are currently receiving benefits from VA, we will cross-reference your information with VA data.

Section III - Insurance Information: Include information for all health insurance companies that cover you, this includes coverage provided through a spouse or significant other. Bring your insurance cards, Medicare and/or Medicaid card with you to each health care appointment.

Directions for Sections IV-IX:

Section IV - Dependent Information: Include the following:

- Your spouse even if you did not live together, as long as you contributed support last calendar year.
- Your biological children, adopted children, and stepchildren who are unmarried and under the age of 18, or at least 18 but under 23 and attending high school, college or vocational school (full or part-time), or became permanently unable to support themselves before age 18.
- Child support contributions. Contributions can include tuition or clothing payments or payments of medical bills.

Section V - Employment Information:

- Veterans Employment Status
- Date of Retirement
- Company Name
- Company Address
- Company Phone Number

Section VI - Financial Disclosure: ONLY NSC AND 0% NONCOMPENSABLE SC VETERANS MUST COMPLETE THIS SECTION TO DETERMINE ELIGIBILITY FOR VA HEALTH CARE ENROLLMENT AND/OR CARE OR SERVICES.

Financial Disclosure Requirements Do Not Apply To:

- a former Prisoner of War; or
- those in receipt of a Purple Heart; or
- a recently discharged Combat Veteran; or
- those who served in a toxic exposure risk activity (TERA); or
- those discharged for a disability incurred or aggravated in the line of duty; or
- those receiving VA SC disability compensation; or
- those receiving VA pension; or
- those in receipt of Medicaid benefits; or
- those who served in an Agent Orange exposure location; or
- those who served in SW Asia during the Gulf War between August 2, 1990 and November 11, 1998; or
- those who served at least 30 days at Camp Lejeune between August 1, 1953 and December 31, 1987.

You are not required to disclose your financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have other qualifying eligibility factors. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information. However, if a financial assessment is used to determine your eligibility for cost-free medication, travel assistance or waiver of the travel deductible, and you do not disclose your financial information, you will not be eligible for these benefits.

Section VII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children
Report:

- Gross annual income from employment, except for income from your farm, ranch, property or business. Include your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses.
- Net income from your farm, ranch, property, or business.
- Other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities.

Do Not Report:

Donations from public or private relief, welfare or charitable organizations; Supplemental Security Income (SSI) and need-based payments from a government agency; profit from the occasional sale of property; income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs); scholarships and grants for school attendance; disaster relief payments; reimbursement for casualty loss; loans; Radiation Compensation Exposure Act payments; Agent Orange settlement payments; Alaska Native Claims Settlement Acts Income, payments to foster parent; amounts in joint accounts in banks and similar institutions acquired by reason of death of the other joint owner; Japanese ancestry restitution under Public Law 100-383; cash surrender value of life insurance; lump-sum proceeds of life insurance policy on a Veteran; and payments received under the Medicare transitional assistance program.

Section VIII - Previous Calendar Year Deductible Expenses

Report non-reimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources. Report last illness and burial expenses, e.g., prepaid burial, paid by the Veteran for spouse or dependent(s).

Section IX - Consent to Copays and to Receive Communications

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

Submitting Your Application

1. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", 2 people you know must witness you as you sign. They must sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete.
2. Attach any continuation sheets, a copy of supporting materials and your Power of Attorney documents to your application.

Where do I send my application?

Mail the original application and supporting materials to the Health Eligibility Center, PO Box 5207, Janesville, WI 54545-5207.

PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0091, and it expires 07/31/2027. Public reporting burden for this collection of information is estimated to average 35 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing this burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0091 in any correspondence. Do not send your completed VA Form 10-10EZ to this email address.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705,1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified from initial submission forward through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

OMB Control No. 2900-0091
Estimated Burden Avg. 35 min.
Expiration Date: 07/31/2027

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

VA DATE STAMP
(For VHA Use Only)

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

TYPE OF BENEFIT(S) APPLYING FOR:

☐ **ENROLLMENT** - VA Medical Benefits Package (Veteran meets and agrees to the enrollment eligibility criteria specified at 38 CFR 17.36)

☐ **REGISTRATION** ***(Complete Sections I, II, and III)*** - VA Health Services (Veterans meets the "Enrollment not required" eligibility criteria specified at 38 CFR 17.37)

1A. VETERAN'S NAME *(Last, First, Middle Name)*	1B. PREFERRED NAME	2. MOTHER'S MAIDEN NAME

3. SEX	4. WHAT IS YOUR RACE/ ETHNICITY? *(Check all that apply. Information is required for statistical purposes only.)*	5. SOCIAL SECURITY NO. *(999-99-9999)*
☐ MALE ☐ FEMALE	☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ HISPANIC or LATINO ☐ MIDDLE EASTERN or NORTH AFRICAN ☐ CHOOSE NOT TO ANSWER	

6A. DATE OF BIRTH *(MM/DD/YYYY)*	6B. PLACE OF BIRTH *(City and State)*	7. PREFERRED LANGUAGE	8. RELIGION

9A. MAILING ADDRESS *(Street)*	9B. CITY	9C. STATE	9D. ZIP CODE	9E.COUNTY

9F. HOME TELEPHONE NO. *(optional) ((999) 999-9999)*	9G. MOBILE TELEPHONE NO. *(optional) ((999) 999-9999)*	9H. E-MAIL ADDRESS *(optional)*

10A. HOME ADDRESS *(Street)*	10B. CITY	10C. STATE	10D. ZIP CODE	10E.COUNTY

11. CURRENT MARITAL STATUS

☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED

12A. NEXT OF KIN NAME	12B. NEXT OF KIN ADDRESS	12C. NEXT OF KIN RELATIONSHIP

12D. NEXT OF KIN TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*	13A. EMERGENCY CONTACT NAME	13B. EMERGENCY CONTACT TELEPHONE NO. *(Include Area Code) ((999) 999-9999)*

14. DESIGNEE - INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH (*Note: This does not constitute a will or transfer of title*)

15. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? *(for listing of facilities visit www.va.gov/find-locations)*	16. WOULD YOU LIKE FOR VA TO CONTACT YOU TO SCHEDULE YOUR FIRST APPOINTMENT? ☐ YES ☐ NO

SECTION II - MILITARY SERVICE INFORMATION

1A. LAST BRANCH OF SERVICE	1B. LAST ENTRY DATE *(MM/DD/YYYY)*	1C. FUTURE DISCHARGE DATE *(MM/DD/YYYY)*	1D. LAST DISCHARGE DATE *(MM/DD/YYYY)*

1E. DISCHARGE TYPE	1F. MILITARY SERVICE NUMBER

2. MILITARY HISTORY *(Check yes or no)*	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	D. WERE YOU DISCHARGED OR RETIRED FROM MILITARY FOR A DISABILITY INCURRED IN THE LINE OF DUTY?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	E. DID YOU SERVE IN SW ASIA DURING THE GULF WAR BETWEEN AUGUST 2, 1990 AND NOVEMBER 11, 1998?	☐	☐
C. DID YOU SERVE IN A COMBAT THEATER OF OPERATIONS AFTER 11/11/1998?	☐	☐	F. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐

APPLICATION FOR HEALTH BENEFITS
Continued

VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NO. *(999-99-9999)*

SECTION II - MILITARY SERVICE INFORMATION *(Continued)*

3. MILITARY EXPOSURE INFORMATION *(Check yes or no)*	YES	NO
A. DID YOU SERVE IN AN IONIZING RADIATION LOCATION AND PARTICIPATE IN ANY NUCLEAR TESTING, TREATMENTS, OR CLEAN UP? (*Hiroshima and Nagasaki cleanup or Enewetak Atoll, cleanup of Air Force B-52 bomber carrying nuclear weapons off the coast of Palomares, Spain, response to the fire onboard an Air Force B-52 bomber carrying nuclear weapons near Thule Air Force Base in Greenland.)*	☐	☐
B. DID YOU SERVE IN ANY OF THE FOLLOWING GULF WAR HAZARD LOCATIONS? *(Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, Yemen, Lebanon, Somalia, Afghanistan, Israel, Egypt, Turkey, Syria, Jordan, Djibouti, Uzbekistan, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, and the Red Sea.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* FROM: TO:	☐	☐
C. WERE YOU DEPLOYED IN SUPPORT OF ANY OF THE FOLLOWING OPERATIONS? *(Enduring Freedom, Freedom's Sentinel, Iraqi Freedom, New Dawn, Inherent Resolve, and Resolute Support Mission)*	☐	☐

	YES	NO
D. DID YOU SERVE IN ANY OF THE FOLLOWING HERBICIDE *(e.g. Agent Orange)* LOCATIONS? *(Republic of Vietnam to include 12 nautical mile territorial waters; Thailand at any United States or Royal Thai base; Laos; Cambodia at Mimot or Krek; Kampong Cham Province; Guam or American Samoa; or in the territorial waters thereof; Johnston Atoll or a ship that called at Johnston Atoll; Korean demilitarized zone; aboard (to include repeated operations and maintenance with) a c-123 aircraft known to have been used to spray an herbicide agent (during service in the Air Force and Air Force Reserves.)* WHEN DID YOU SERVE IN THESE LOCATIONS? ***NOTE:*** *Please provide an approximate time-frame (MM/YYYY)* FROM: TO:	☐	☐

E. HAVE YOU BEEN EXPOSED TO ANY OF THE FOLLOWING? *(Check all that apply)*
Veterans can locate additional military exposure categories on VA's Public Health website at: https://www.publichealth.va.gov/exposures/

- ☐ AIR POLLUTANTS *(burn pits, sand, oil well/sulfur fires)*
- ☐ CHEMICALS *(pesticides, herbicides, contaminated water)*
- ☐ CONTAMINATED WATER AT CAMP LEJEUNE
- ☐ RADIATION ☐ SHAD *(Shipboard Hazard and Defense)*
- ☐ OCCUPATIONAL HAZARDS *(jet fuel, industrial solvents, lead, firefighting foams)*
- ☐ ASBESTOS ☐ MUSTARD GAS
- ☐ WARFARE AGENTS *(nerve agents, chemical and biological weapons)*
- ☐ OTHER *(Specify)*:

WHEN WERE YOU EXPOSED?
NOTE: *Please provide an approximate time-frame (MM/YYYY)*
FROM: TO:

SECTION III - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ENTER YOUR HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER *(include coverage through spouse or other person)*

2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE

5. ARE YOU ELIGIBLE FOR MEDICAID? *(Federal health insurance for low income adults)*	6A. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	6B. EFFECTIVE DATE *(MM/DD/YYYY)*	6C. MEDICARE NUMBER
☐ YES ☐ NO	☐ YES ☐ NO		

SECTION IV - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*

1A. SPOUSE'S SOCIAL SECURITY NUMBER

1B. SPOUSE'S DATE OF BIRTH *(MM/DD/YYYY)*

1C. SPOUSE'S SEX
☐ MALE ☐ FEMALE

1D. DATE OF MARRIAGE *(MM/DD/YYYY)*

1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP if different from Veteran's)*

3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, DID YOU PROVIDE SUPPORT?
☐ YES ☐ NO

2. CHILD'S NAME *(Last, First, Middle Name)*

2A. CHILD'S DATE OF BIRTH *(MM/DD/YYYY)*	2B. CHILD'S SOCIAL SECURITY NO. *(999-99-9999)*

2C. DATE CHILD BECAME YOUR DEPENDENT *(MM/DD/YYYY)*

2D. CHILD'S RELATIONSHIP TO YOU *(Check one)*
☐ SON ☐ DAUGHTER ☐ STEPSON ☐ STEPDAUGHTER

2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18?
☐ YES ☐ NO

2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR?
☐ YES ☐ NO

2G. EXPENSES PAID BY YOUR DEPENDENT CHILD WITH REPORTABLE INCOME FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)*

APPLICATION FOR HEALTH BENEFITS *Continued*	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NO. *(999-99-9999)*

SECTION V - EMPLOYMENT INFORMATION

1A. VETERAN'S EMPLOYMENT STATUS *(Check one)*.

☐ FULL TIME ☐ PART TIME ☐ NOT EMPLOYED ☐ RETIRED

1B. DATE OF RETIREMENT *(MM/DD/YYYY)*

1C. COMPANY NAME. *(Complete if employed or retired)*	1D. COMPANY ADDRESS *(Complete if employed or retired - Street, City, State, ZIP)*	1E. COMPANY PHONE NUMBER *(Complete if employed or retired) (Include area code) ((999) 999-9999)*

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain Veterans will be charged copays for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information. Veterans who choose not to disclose financial information may not be eligible for enrollment or may be responsible for any applicable VA copayments, if they are enrolled. **Recent Combat Veterans (e.g., OEF/OIF/OND)** may answer YES in Section VI and complete Sections VII and VIII to have their priority for enrollment and financial eligibility for travel assistance, cost-free medications and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through VIII.** If I am enrolled, I agree to pay applicable VA copayments. Sign and date the form in the Assignment of Benefits section.

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable Sections VII and VIII. Sign and date the form in the Assignment of Benefits section.

SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN

(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS			
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS			
3. LIST OTHER INCOME AMOUNTS *(e.g., Social Security, compensation, pension, interest, dividends)* EXCLUDING WELFARE.			

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VI.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION IX - CONSENT TO COPAYS AND TO RECEIVE COMMUNICATIONS

By submitting this application, you are agreeing to pay the applicable VA copayments for care or services (including urgent care) as required by law. You also agree to receive communications from VA to your supplied email, home phone number, or mobile number. However, providing your email, home phone number, or mobile number is voluntary.

ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729 and 42 U.S.C. 2651, the Department of Veterans Affairs (VA) is authorized to recover or collect from my health plan (HP) or any other legally responsible third party for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse. Furthermore, I hereby assign to the VA any claim I may have against any person or entity who is or may be legally responsible for the payment of the cost of medical services provided to me by the VA. I understand that this assignment shall not limit or prejudice my right to recover for my own benefit any amount in excess of the cost of medical services provided to me by the VA or any other amount to which I may be entitled. I hereby appoint the Attorney General of the United States and the Secretary of Veterans' Affairs and their designees as my Attorneys-in-fact to take all necessary and appropriate actions in order to recover and receive all or part of the amount herein assigned. I hereby authorize the VA to disclose, to my attorney and to any third party or administrative agency who may be responsible for payment of the cost of medical services provided to me, information from my medical records as necessary to verify my claim. Further, I hereby authorize any such third party or administrative agency to disclose to the VA any information regarding my claim.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT *(Sign in ink)* _____

DATE *(MM/DD/YYYY)* _____

TOBACCO-FREE CAMPUS

Policy: Tobacco-Free Campus

Responsibility: Administrator

Infection Control: Standard Precautions

Purpose:

It is the policy of this facility to provide the residents with a safe and comfortable environment that includes prohibiting the use of all tobacco and tobacco related products on campus, including electronic smoking devices.

Procedure:

1. This campus-wide tobacco-free policy will apply to:
   a. Residents
   b. Employees
   c. Customers, vendors, clients, consultants, contractors, and all other visitors
2. Smoking, including electronic cigarettes and tobacco use of any kind will be prohibited on the premises, to include all internal and external areas, parking lots, and all entrances and exits.
3. Employees who choose to use tobacco products must do so on their regularly scheduled unpaid meal period and off facility campus.

III. INTERPRETATIONS AND GUIDELINES

A. Residents currently waiting for transfer, and all future applicants for admission to the facility will be made aware both verbally and in writing regarding the facility policy.

B. Any resident seeking admission to the facility will be given education to begin a smoking cessation program as soon as possible. This should be under the guidance of a health care professional or physician.

C. Veterans who have resided at the facility prior to this change in policy will be "grandfathered" for the duration of their stay and will be permitted to smoke or use tobacco products in specially designated areas on the campus. smoking/tobacco use sessions will be scheduled and supervised by facility personnel.

Any "grandfathered" resident will require the following in order to continue smoking/tobacco use privileges:

- Smoking screen
- Supervised smoking sessions at designated times and in designated areas only
- Must wear a smoking apron
- Current smoking care plan
- Smoking and all types of tobacco products will be secured by the nursing staff, to include lighters and matches
- Facility personnel reserve the right to periodically check rooms of resident smokers if there is a reason to believe smoking or tobacco materials are not being stored per policy
- Residents who do not comply with this policy are subject to discharge

Any "grandfathered" resident smoker who wishes to discontinue smoking or tobacco use will be assisted to meet this goal with an individualized smoking/tobacco cessation program.

SC DEPARTMENT OF VETERANS' AFFAIRS

LEAD ★ SERVE ★ REMEMBER

ACKNOWLEDGMENT OF A TOBACCO-FREE CAMPUS

SOUTH CAROLINA STATE VETERANS HOMES

This is to acknowledge that I have received and read a copy of the Tobacco-Free Campus Policy.

I understand that it contains important information on the facility's policy regarding tobacco free campus.

My signature indicates agreement to comply with the Tobacco-Free Campus Policy.

_____ _____

Resident/Resident Representative Signature **Date**

_____

Resident/Resident Representative Name (printed)

_____ _____

Witness Signature **Date**

SOUTH CAROLINA STATE VETERANS HOMES

Please list information for any physician who will be supplying progress notes

APPLYING VETERAN NAME: _____

PHYSICIANS / PROVIDERS	NAME	ADDRESS	PHONE #	Upcoming Appointments
PRIMARY CARE PHYSICIAN				
DENTAL				
DERMATOLOGY (Skin)				
EAR/NOSE/THROAT				
G.I. (Gastrointestinal)				
NEPHROLOGY (Kidney)				
NEUROLOGY (Nervous System)				
OPTHALMOLOGY (Eye)				
ORTHOPEDICS (Bones)				
PODIATRY (Foot)				
PULMONOLOGY (Lungs)				
OTHER:				
CARDIOLOGY (Heart)				
PACEMAKER/DEFIBRILLATOR				
MODEL NAME:				
DATE IMPLANTED:				
PHYSICIAN/SURGEON:				

PART 2
MEDICAL INFORMATION

SOUTH CAROLINA STATE VETERANS HOME

Please give this packet to the Veteran's physician or medical staff.

This medical information will need to be completed and returned to the family/Veteran to submit with the completed application. The application will be considered incomplete if all of the required information is not provided. An incomplete packet will delay the admission process. The information will be valid for 12 months only.

Note to the Physician

1. Health Care Decision Form
2. SLUMS examination (1 page-VAMC Form) - Nursing/Social Work may complete and sign
3. PASARR (2 pages) - Nursing/ Social Work may complete and sign
   - Level II PASARR is required if diagnosis/history of MI and /or MR
4. The State Veterans Home will require an admission/baseline 2-step Tuberculin Skin Test (TST) or a single BAMT within one (1) month prior to admission unless there is a documented TST or a BAMT result during the previous twelve (12) months. If the veteran has a documented negative TST or a BAMT result within the previous twelve (12) months, a single TST (or the single BAMT can be administered within one (1) month prior to admission to the facility to serve as the baseline.

   Veterans with a baseline positive or newly positive test result (TST or BAMT) or documentation of treatment for latent TB infection (LTBI) or TB disease or signs and symptoms of tuberculosis shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy taken within the previous three (3) months).

5. The following will also need to be included with the medical information:
   - History and Physical
   - Last 2-3 months of Physician office visits
   - Inclusive Diagnosis/ Nursing/ Therapy notes
   - Recent discharge summaries from facilities
   - Current Medication Administration Record (MAR) or medication list
   - Current Immunization Records

HEALTH CARE DECISION FORM

Veteran's Name:_____

Veteran is able to make decisions related to his/her Health Care. Please describe:

_____

_____

_____

_____ _____

Physician Signature Date

Inability to make health care decisions must be determined by **two** licensed physicians.

1. ATTENDING PHYSICIAN STATEMENT: Physician must state an opinion regarding the CAUSE and NATURE of inability to make health care decisions, and its probable DURATION.

_____

_____

_____

_____

_____ _____

Physician Signature Date

2. ATTENDING PHYSICIAN STATEMENT: Physician must state an opinion regarding the CAUSE and NATURE of inability to make health care decisions, and its probable DURATION.

_____

_____

_____

_____

_____ _____

Physician Signature Date

VAMC
SLUMS EXAMINATION

Questions about this assessment tool? E-mail aging@slu.edu

Name_____ Age_____

Is the patient alert?_____ Level of education_____

__/1 (1) **1. What day of the week is it?**

__/1 (1) **2. What is the year?**

__/1 (1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

(1) **How much did you spend?**

__/3 (2) **How much do you have left?**

6. Please name as many animals as you can in one minute.

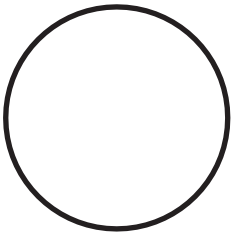
__/3 (0) 0-4 animals (1) 5-9 animals (2) 10-14 animals (3) 15+ animals

__/5 **7. What were the five objects I asked you to remember? 1 point for each one correct.**

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.

__/2 (0) 87 (1) 648 (1) 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay

__/4 (2) Time correct

(1) **10. Please place an X in the triangle.**

__/2 (1) **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

__/8 (2) **What was the female's name?** (2) **What work did she do?**

(2) **When did she go back to work?** (2) **What state did she live in?**

_____ **TOTAL SCORE**

SCORING

High School Education		Less than high school education
27-30	Normal	25-30
21-26	Mild Neurocognitive Disorder	20-24
1-20	Dementia	1-19

CLINICIAN'S SIGNATURE DATE TIME

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morley. The Saint Louis University Mental Status (SLUMS) Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriatr Psych* 14:900-10, 2006.

Name:	Date of review:
SSN:	Location at assessment:
Medicaid: Non-Medicaid:	CLTC#:
Date of birth:	Referral source:
All Diagnosis (If dementia diagnosed or suspected, complete and attach the Mini-Mental Form):	

I. SCREENING FOR MENTAL RETARDATION INDICATORS:

	YES	NO
1. Diagnosis of mental retardation or related disability made prior to age 22?		
2. IQ tested below 70?		
3. Was time of test prior to age 22?		
4. Does client have 3rd grade education? If not, state reason in Comments Section.		
5. Adaptive behavior: Could client ever perform self-care activities?		
- Did he/she help care for spouse/parents/children?		
- Was client ever able to cook and perform household duties?		
- Was client gainfully employed? If not, explain in Comments Section.		
- Did client have driver's license?		
6. Cognitive Functioning:		
- Memory: Does Client remember what he/she had for breakfast or lunch?		
- Simple math: Can client add 12 + 8?		
- Concept formation: Can client describe the different between a fish and dog?		

7. Comments: _____

_____

II. SCREENING FOR MENTAL ILLNESS INDICATORS:

1. Diagnosis of mental illness: No_____ Yes_____ Diagnosis: _____

2. History of psychiatric hospitalization within previous two years. *(Give dates of treatment)* If no hospitalization, indicate here: _____

___/___/___ to ___/___/___ ___/___/___ to ___/___/___ ___/___/___ to ___/___/___

3. Current behavioral indicators:

Attempted suicide _
Assaultive __
Incessant loud talking ____
Uncooperative __
Hostile __
Unrealistic fear of strangers _
Self-mutilation __
Combative __
Social isolation __
Destruction of property ___
None of these indicators: ____

4. Comments: (Include explanation of major symptoms): _____

_____

Name: _____ SSN: _____

III. LIST ALL PSYCHOTROPIC DRUGS PRESCRIBED INCLUDING DOSAGE AND FREQUENCY.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

IV. RECOMMENDATION OF REVIEWER:

_____ Recommend further evaluation based on mental retardation indicators.
_____ Recommend further evaluation based on mental illness indicators.
_____ No further evaluation recommended.
_____ No further evaluation recommended, but indicators present. (State reasons below)

_____

_____

Comments: (Give justification for above recommendations, if needed.)

_____

_____

V. PERTINENT INFORMATION

_____ Primary diagnosis of dementia; must be confirmed by a Mini-Mental Form.

Information obtained from: _____ CLTC Area# _____

Signature and title of assessor: _____

Agency/Institution completing form: _____

Admitting Nursing Facility: _____Date of Admission (if known) _____

FOR CLTC/IOC USE ONLY **FOR CLTC USE ONLY**

Reviewed by Nurse Consultant _____(initials)

Date reviewed: _____

VI. ADVANCE CATEGORICAL DETERMINATION

_____ Advance categorical determination that specialized in services are not required:

_____ 1. Severity of physical impairments overrides need for specialized services (MI only)
_____ 2. Nursing facility respite not to exceed 14 days (MR or MI)
_____ 3. Emergency admission due to suspected abuse/neglect under authority of DSS (MR or MI)
_____ 4. 30-Day time limited certification (MR or MI)
_____ 5. Mental retardation with concurrent diagnosis of dementia (MR only)

Signature of CLTC Nurse Consultant: _____

Date sent to nursing facility: _____ Initials: _____

Tuberculin Skin Test Record

Veteran Information:

Name:_____

Date of Birth:_____ –

Step 1: Skin Test Information

Date Administered:_____

Arm on which Administered:_____ -

Step 1: Results

Date of Reading:_____

Induration:_____mm

Comments and Adverse Reaction(s), if any:_____

_____

Step 2: Skin Test Information

Date Administered:_____

Arm on which Administered:_____

Step 2: Results

Date of Reading:_____

Induration:_____mm

Comments and Adverse Reaction(s), if any:_____

Completed By:_____

(TST must be completed prior to admission unless contraindicated.)

Immunization Record

Veteran Name:_____

Date of Birth:_____

Influenza Vaccine:

Date Received:_____

Location Received:_____

Tetanus Vaccine:

Date Received:_____

Location Received:_____

Pneumo 23 Vaccine:

Date Received:_____

Location Received:_____

Prevnar 13 Vaccine:

Date Received:_____

Location Received:_____

COVID Vaccine: Dose #1

Date Received:_____

Location Received:_____

COVID Vaccine: Dose #2

Date Received:_____

Location Received:_____

Bivalent Booster:

Date Received:_____

Location Received:_____

Completed By:_____